Dubuque IA Health Link Public Comment Meeting

Wednesday, October 11, 2017
Time: 5 p.m. – 7 p.m.
Grand River Center
Meeting Room 6
500 Bell St.
Dubuque, IA 52001

Meeting Comments and Questions

IME/DHS Staff	MCO Representatives	MAAC Representatives
Lindsay Paulson **- present**	Amerigroup Iowa, Inc. **- present**	Dennis Tibben **- present**
Sean Bagniewski **- present**	AmeriHealth Caritas Iowa, Inc. **- present**	Sue Whitty - **present**
Alisha Timmerman **- present**	UnitedHealthcare Plan of the River Valley, Inc. **- present**	
Peter Crane **- present**		

Comments

Services and Provider Network

- Following implementation, a member was required to obtain a new Primary Care Physician (PCP). When the member recently began treatment with her new provider, the provider assisted in locating new specialists although the member's new provider network would require the member to travel distances further than 50 miles from her home for services. The member was told that one of the specialists was within the member's MCO provider network and accepting new patients although when the member contacted the provider to schedule an appointment, the provider stated that they were not accepting new patients.
- A different mother stated that her daughter had suffered a traumatic brain injury and was in a coma for seven months. The member began habilitation services following her release from the hospital although at the beginning of this year, the member was placed in a residential group home; this did not provide the proper treatment for the member's condition. The member's MCO re-evaluated the member's needs and the MCO allowed an Exception to Policy (ETP) for the member to live alone with staff. In February 2017, the member and member's guardian were notified that the member's MCO would be reducing the member's funding for services by 43% and the family was then required to pay the remainder for 24 hour staff. Two of the member's staff discontinued services due to uncertainty of job security. With the reduction of funding and limited staff, the family was providing the remaining necessary services for the member. The member's family contacted nursing homes in the member's area but they had waiting lists and/or stated that they were not able to provide the level of care necessary for the member. The member's father stated that the family was on a fixed income and that this has created hardship for the family.

- It was stated that a member had been successful when receiving respite care although the program discontinued.
- A father stated that his son's providers were ending their contracts with the MCOs and/or no longer serving Medicaid members and that he was concerned about the well-being of his son.
- A provider at a Community Health Center stated that there were problems with the number of providers accepting a particular MCO as members were having to change their MCOs and wait for services until their MCO change would take effect. There are also issues with MCO choice cut-off dates and MCO changes taking 4-6 weeks to process while members go without services during that time. The provider stated that they would like to change the choice-cut-off dates to something less than 4-6 weeks. There had to be more providers and clinicians available in Dubuque who are contracted with all MCOs. Members were having to travel longer distances for doctor appointments although were not eligible for Non-Emergent Medical Transportation (NEMT) services therefore were unable to go to appointments.
- Members were being required to complete a Health Risk Assessment (HRA) with the IME, MCO, and then complete an Oral Health Self-Assessment; this process is time consuming for both members and providers.
- In regards to mental health, it takes up to 30-45 days for a Medicaid application to process although members receiving mental health services require assistance sooner for access to services.
- A provider stated that the MCOs do not understand the Iowa Administrative Code (IAC) and that services are being denied that under Fee-for-Service were always approved. The MCOs are implementing standards for Behavioral Health Intervention Services (BEHIS) services that are not required per the IAC. The provider indicated that a member of her staff will spend many hours authorizing services for children that are on the Children's Mental Health (CMH) Waiver as the MCH HCBS Waiver portal requires extensive amounts of time.
- A mother received a letter from AmeriHealth Caritas Iowa, Inc. stating that the member would no longer have diabetic foot care. The mother called the IME and was told that the MCO could determine which services the member received and the IME would no longer make these determinations. The mother called the Rapid Response Team and was told to contact Governor Branstad. She was told that the services have to be medically necessary although the member was eligible for the services prior to implementation. Her son no longer has foot care and he does not have disposable income.
- A mother stated that there had been a reduction in the number of medical shoes available to the member per year. Prior to implementation, the member received 2 pairs of shoes per year and now the member is only able to receive one pair of shoes per year because each shoe is counted separately.

Prior Authorizations

- An oncologist stated that he recently had two patients who required medication for cancer and it took over two weeks for prior approval of the medications. The provider stated that this has happened on several other occasions and that will no longer be working with the MCO.

Case Management

A parent stated that MCO Case Managers are frustrating to deal with as they are not knowledgeable and admit that they are not aware of policies and/or procedures.

Home- and Community-Based Services (HCBS) Waiver

- A parent of a member on the Intellectual Disability (ID) Waiver stated that their son was currently receiving and living off of Social Security Income (SSI) due to the limited availability of prevocational programs. It was affirmed that Waiver services should be carved out of the IA Health Link managed care program. Additionally, there were too many assessments and they occurred far too frequently; Supports Intensity Scale (SIS) Assessment, Level of Care Assessment, and Case Management Risk Assessment. The parent spoke with the Ombudsman and requested why the member was not waived from the SIS assessment although did not find resolution.
- A provider affirmed that there was not enough funding available for necessary services and that their organization was recently notified that 30% of HCBS providers in Iowa will take significant pay cuts.
- A mother stated that she had started a community-based home with Hills & Dales where her son and 3 other adult Medicaid members were transitioned from institutions. The behaviors of all 4 of the adults had improved in the new setting although now, due to SIS Assessment and Level of Care, the members' services were being reduced. Due to the reduction of her son's services, the member's mother would now be required to take care of the member and due to the member's behavioral issues; the mother would now be in a dangerous situation. Alternately, the member may also be placed in an out-of-state facility given the nature of the member's level of care needs.
- A father of a son on the Intellectual Disability Waiver said that he was concerned about HCBS providers and what will happen to the services if providers continue to no longer serve Medicaid members. His son is currently employed in an integrated setting within the community although he may be losing employment services.
- A mother indicated that the day prior her daughter was told that she would no longer be able to work at her current job due to cut-backs and subsidies. She stated that her daughter had tried vocational rehab although her daughter had been more successful with her current position.

Consumer Choices Option (CCO)

- There have been rumors of Consumer Choices Option (CCO) being forced out and this has caused stress on family members and the member's employees. CCO does not have a provider network to address issues.

- A parent stated that CCO employees were not being paid a livable wage due to costs associated with being a provider and their need to get private medical insurance. MCO case managers do not seem to understand how funding works between Veridian and members which has caused major delays in services and employee paychecks. The amount of time spent traveling, the cost of gas, scheduling fact-to-face meetings, and ensuring signatures on timesheets has become a burden on Independent Support Brokers (ISBs). Guardians and members are agitated that they must schedule a time each month to sign one piece of paper. Most ISBs have other jobs although they are having to take calls from Veridian and the members' case managers during the day, while at their other place of employment, due to timesheet and paperwork issues. The MCOs are also not interpreting Iowa regulations correctly and include CCO in some of the traditional service regulations.
- A CCO provider indicated that individuals received better care with CCO because the members hire their own staff which allows them to be more independent than if the member were with an agency. The provider stated that they had a meeting with the State and MCOs where it was identified that CCO services were saving the State money although the MCOs were instead forcing members to go to nursing homes or utilize alternate services that cost more money.
- Another mother identified that her son uses CCO because of the quality of care it provides. The member had tried three different agencies in the Dubuque area although they were not the proper fit for the member and were not being accountable. The mother and son had asked the last agency specific information regarding the billing and services provided although they did not provide the requested information. The mother asked who paid for her son's services and they stated, "Medicare, that's not your problem." Additionally, she stated that the rates continued to fluctuate which created uncertainty in service provisions.

Consumer Directed Attendant Care (CDAC)

CDAC providers are paid at a very low rate and members are requesting a higher rate to retain their CDAC providers although the MCOs are rejecting their requests.

Communications, Oversight, and General Comments

This meeting was poorly advertised. Most people are unaware of upcoming meetings as they do not look at the IME website for upcoming meetings. Many members also may not be able to afford transportation to get to meetings. In regards to assistance with concerns or issues, members are not aware of who to contact for assistance. A parent requested better transparency from the State and MCOs to have additional information regarding how funds were being used. It was stated that the State needs to find a way to get rid of privatization. Medical Assistance Advisory Council (MAAC) member Sue Whitty stated that the MAAC had taken the input from meetings into consideration and made 19 recommendations to Director Foxhoven although one was taken into consideration while the other 18 received notice of denial; the MAAC will continue to make recommendations. It was also stated that staff were having to spend too much time working on MCO issues and it was taking time away from members. A provider stated that every month they are given lists of members and are being asked to reconcile the lists which requires the providers to check the accuracy of the MCOs

work. A provider was concerned that members were required to take HRAs online and some members or member representatives do not have access to the internet or only have internet on their phone. Senator Pam Jochum stated that she has not seen improvement in the program following implementation and her daughter is not receiving the services that she needs such as day habilitation and Supported Community Living (SCL) services. Senator Jochum' s daughter is currently receiving 3 hours of SCL because local providers cannot hire anyone as they cannot offer a competitive wage. Senator Jochum, Representative Chuck Isenhart, and Representative Shannon Lundgren informed the Public Comment Meeting participants that the legislature was frustrated that they have been taken out of the process and that the Executive branch has chosen to privatize Medicaid. The Senator and Representatives advised their constituents that they are encouraged to participate in changing the program by contacting their Senators, Representatives, and the Governor to voice concerns so that they are better able to see where modifications need to be made when considering future changes.

Reimbursement

A mother stated that her daughter had 10 providers prior to implementation although, due to providers not being reimbursed for services rendered, her daughter will have 5 providers beginning November 1, 2017.

Tiered Rates

A provider and a member stated that they had not yet received information regarding tiered rates.

Billing, Claims, and Credentialing

A provider had contracts with all MCOs. In August, claims for inpatient stays were denied by one of the MCOs although Case managers at the provider's hospital verified that the proper criteria had been met prior to submission and following the denials. A Case Manager supervisor called the MCO regarding this issue and a representative from the MCO stated that if you have a patient with a one night stay, they were going to deny the claim and then the MCO would have to go through a Peer-to-Peer review and a longer process. Provider is also experiencing denials for Durable Medical Equipment as the MCO has stated that the hospital is not in-network and not credentialed with the MCO. The provider has provided evidence of network status although the claims continue to be denied. Additionally, the provider is not being paid at least 100% of the Medicaid fee schedule and one of the MCOs is paying based off of the Medicare fee schedule. The provider currently has 31 outstanding payment issues with one of the MCOs that have not yet been resolved.

Non-Emergent Medical Transportation

Providers are not available in Dubuque and members were having to travel further distances to get to appointments. Members eligible for NEMT were having difficulty with NEMT brokers as the brokers were not picking the members up and members were then missing their appointments. Members who missed appointments were at risk of their provider no longer seeing them due to missed appointments.

Questions

1. Are CCO services being forced out?

2. What kind of training has been provided to the MCOs regarding CCO?

3. What kind of training has been provided to MCO case managers?

4. Where can CCO Independent Support Brokers (ISBs), members and family address issues with the MCOs directly?

5. Do the MCO understand CCO does not follow many of the traditional service relations and that services are consumer driven?

6. Do the MCOs understand Pay Rates for CCO employers are higher than traditional services because CCO employees do not receive benefits of any kind?

7. Why have Supported Community Living (SCL) and Respite transportation funds been eliminated although work transportation has not?

8. Initiating CCO services and processing background checks can take between 4 to 6 weeks for approval which is creating a delay in services and lack of employees for assistance. What is being done to improve this?

9. When will CCO budget forms be updated?
    a. Can it be adjusted to reflect the new ISB pay rate?
    b. Can the form have an area added for who the Medicaid provider is?
    c. Can the form have an area added for Case Manager name and contact information?
    d. Can the form be adjusted to show the member's waiver?
    e. Can a comments area be added for special notes?

10. Why do some Case Managers require new budgets be submitted every 3 months, regardless of whether or not there have been changes to rates?

11. Can rules be changed so that ISBs do not need to turn in timesheets and have a set pay rate of $30 a month?

12. Can waiver services be placed under the state as they had been prior to implementation?

13. CCO services are much less expensive than traditional agency services; why are the MCOs reducing CCO services?

14. Can the MCOs and State have a CCO only training, or at least a Dubuque area meeting, to address questions from members, their families, and employees?

15. Is there a way to get a summary of what was presented in the meeting and then receive a response from leadership to the concerns raised?

16. Does the MAAC have the authority to address these concerns or bring them forward to leadership to ensure they are addressed?

17. There is too much paperwork required to obtain services. Why can't they cut back on some of the paperwork and make the processes less difficult; revert to previous processes and requirements?

18. Who is responsible for making these determinations regarding budget? The MAAC, legislators, etc.?

19. Does the governor get information from these meetings?

20. Why have we not had a meeting in Dubuque since May of 2016?

21. Why did the State make this change? What was wrong with the way that Medicaid was previously run?

22. A provider affirmed that there was not enough funding available for necessary services and that their organization was recently notified that 30% of HCBS providers in Iowa will take significant pay cuts. Where is the money going?

23. In March 2019, HCBS setting rules are going into effect. How are we going to pull this off?

24. What is difficult to assess is the cost of staff time. What amount of funding is to be used for staff time; taking time to speak with members/representatives/providers? How much extra money is this costing the State?

25. What are the MCOs doing with the money and what are they doing with the money from all of the unpaid claims?

26. Can anything be done to change these policies?

27. What are you doing to learn managed care?

Formal Written Comments

Name: Rosalie Jahn

Organization: Nurse – Mercy Medical Center – Mental Health/Substance Abuse

Comments / Questions:

1. Why was there a change in retroactive eligibility insurance coverage for hospitalizations of patients who let their coverage lapse? Specifically for acutely mentally ill patients this is a consistent problem due to the nature of their illness and lack of supports that they don't meet the requirements to keep their insurance active. Then, they end up being hospitalized and have a huge bill they can't pay. Could there be some type of waiver or provision on this policy for this highly vulnerable population?

2. It is not a secret that we are in the middle of an opioid crisis. People are dying and your current policies are contributing to that.
   a. Prior Authorization to cover Suboxone is not timely; up to 10 days to wait for these patients to get approval.
   b. Dose Limits. Coverage is for only up to 16 mg/day. There are a number of patients that require more.
   c. Denials of coverage because of the dose regimen. Typically, 16 mg is supplied in (2) 8 mg sublingual films; these are not supposed to be cut. The doctor may prescribe 12 mg a.m., 4 mg p.m. or 4 doses of 4 mg throughout the day for better coverage. The Suboxone coverage is denied because the way the dose is written. This makes no sense and looks like the insurance company knows more about how to prescribe this than the doctor.

Formal Written Comments

Name: Bill Stumpf

Organization: Parent of Kyle Stumpf

Comments / Questions:

I thought things were somewhat stable in terms of Kyle's medical providers and now it seems that another one of Kyle's providers is discontinuing its contract with his MCO. Specifically, what is being done to bring them back in? I am also concerned about Kyle's HCBS providers and if they will continue to be able to provide services. The only thing that keeps things going well is because Kyle is dual eligible. He works in the community. If he loses his HCBS providers he will be at risk of losing his integrated employment. With the HCBS Settings Rule going into effect in March of 2019, how will the levels of service be able to keep up with the true spirit of HCBS services?

General Comments: Dental Wellness Plan and FFS Dental

- There are currently no available dental providers in Dubuque.
- Members in the Dental Wellness Plan were tentatively assigned to dental carriers and there are a limited number of dental providers accepting Medicaid members. Members were often required to change their dental carrier although it could take up to 4-6 weeks for the change to process which resulted in a lapse in care.